General Principles of Pain Control for the Dying
(Part I)

GOALS

- To understand the common barriers to effective pain management
- To learn how to perform a pain and addiction assessment
- To learn to identify common pain syndromes in the dying patient
- To become familiar with the WHO analgesic ladder
- To learn basic prescribing rules for opioid and non-opioid analgesics

I. ADDICTION ASSESSMENT

A. Definitions

1. Tolerance - need to increase the amount of drug to obtain the same effect..

2. Physical dependence - development of withdrawal reaction upon discontinuation or antagonism of drug.

3. Pseudoaddiction - behavioral manifestations of addiction occurring as a result of undertreated pain; typically in the setting of severe continuous pain when drugs are administered at inadequate doses at excessive dosing intervals.

4. Addiction (aka psychological dependence) - overwhelming involvement in the acquisition and use of drugs for non-medical purposes. Tolerance and physical dependence may or may not be present. The presence of tolerance or physical dependence does not prove psychological dependence. Criteria suggesting addiction include:

- continued use despite negative personal, medical and legal problems;

- frequent intoxication at times when one is expected to fulfill major life roles or when substance abuse is dangerous;

- much time spent in obtaining, using and thinking about drug abuse;

- reduction in important social, occupational or recreational activities due to substance abuse.

B. Evaluating Pain

1. Autonomic signs or physical behaviors (e.g., crying, grimacing, etc.) are not useful for deciding when a patient is in pain.

2. Use a scale to quantify pain.

3. Use quality descriptors and ask about impact on activities of daily living.

4. Chart pain reports frequently and response to treatment.

C. Assessment of Potential Addiction

Obtain a complete database of information relative to addiction concerns. Sources can include the patient, family members, treating physicians, emergency room and pharmacy records. Important questions related to addiction assessment include:

1. Treatment plan reliability

- compliance with prescribed drugs

- follow-up with clinic visits and recommended consultations

2. Loss of control of drug use

- are there partially used bottles of medicines at home?

3. Drug-seeking behaviors

- "lost medications"
- demands for drugs of high street value
- "allergies" to many opioids
- scripts from many MD's filled at many pharmacies

- frequent ER visits for refills

4. Abuse of other drugs

    - ETOH, benzodiazepines, cocaine, heroin, amphetamines

5. Contact with street culture

    - friends/family who are users

6. Adverse life consequences

    - loss of job, marriage, children due to drugs
    - legal and medical problems due to drugs

II. THE PAIN PROBLEM

A. 60-90% of cancer patients with advanced disease experience moderate to severe pain.

B. Nearly all pain can be adequately treated

III. PAIN ASSESSMENT

A. Neurophysiological mechanisms of pain

1. Somatic

2. Visceral

3. Neuropathic

B. Temporal pattern of pain

1. Acute pain

2. Chronic pain

3. Breakthrough pain

C. Pain intensity

IV. NON-OPIOID ANALGESICS

A. Acetaminophen

B. Salicylates

C. NSAIDS

1. Propionic Acids (ibuprofen, oxaprozasin-Daypro)

2. Arylacetic Acids (Naproxen, fenoprofen-Nalfon, ketoprofen-Orudis)

3. Indoles (indomethacin, tolmetin-Tolectin, sulindac-Clinoril)

4. Oxicams (piroxicam-Feldene)

V. OPIOID ANALGESICS

A. For severe pain, oral morphine is the usual drug of choice

B. Avoid PRN dosing

C. Don't use Demerol!

- Side effects
- Pain Relief
- No pain relief
- PRN DOSING
- Side effects
- Pain Relief
- No pain relief
- ROUND THE CLOCK DOSING!

D. Routes of Administration

1. Onset of Analgesia

- IV: 5-10 minutes
- SQ or IM: 20-40 minutes
- PO: 20-60 minutes
- Rectal/sublingual similar to sq/IM

2. Oral Administration is Preferred Route

- More even blood level
- Cheaper

- Less intimidating
- Does not need skilled staff
- No needles, no infections

3. Highly Concentrated oral solutions

4. Transdermal Fentanyl (25ug-100ug patches)

    - 25ug/hour patch = 10mg oral morphine every four hours

5. IV versus subcutaneous

6. Patient Controlled Analgesia

    - subcutaneous pumps

7. Intraspinal (epidural or intrathecal)

VI. ADJUVANT THERAPIES

A. Adjuvant analgesic drugs

1. anticonvulsants

2. antidepressants

3. antihistamines

4. steroids

5. antibiotics

B. Neurolytic blocks and neurosurgery

C. Acupuncture and TENS

D. Relaxation techniques